Meeting

Summary

Business Plan Work Group

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Indian Health Service

IHS to Develop Business Plan

INSIDE

IHS Business Plan Meeting Summary
Indian Health Service

This issue summarizes the proceedings of the Business Plan Work Group meeting held in Albuquerque N.M. on December 11 and 12.

Phone John Breuninger on 505-837-4101 or Cliff Wiggins on 301-443-7261 for more information. Submit fax suggestions on 505-837-4115, attention John Breuninger.

Business Plan Goals

The Indian Health Service (IHS) is developing a business plan to accomplish the following goals:

- assure Indian health programs are economical and financially solvent while preserving health services, and
- apply lessons learned from the business community to improve and enhance the agency's performance, accountability and value to Indian people.

Need for Business Plan

Michel Lincoln, co-chair of the Business Plan Work Group, welcomed new work group members by describing the reasons why Dr. Trujillo, Director, IHS, has charged the group to develop a business plan. He described an agency that is undergoing substantial change. Budgets are flat while costs continue to rise. Tribes are assuming health services delivery responsibilities and agency resources to carry out those responsibilities. Third party collections (funds collected from Medicare, Medicaid, and private insurance) are increasingly critical as a supplement to appropriations. Dr. Trujillo sees these and other forces continuing to strain the agency's capability to meet its health mission to Indian people.

Mr. Lincoln described a broad strategy to initiated by the Director to redesign IHS to meet these challenges immediately and in years to come. Realistic business planning is part of the Director's strategy to assure that Indian health programs are both economical and a valued asset to Indian people well into the twenty-first century. Prudent long range planning also is necessary to furnish tribes with the maximum self-determination opportunities for contracting, compacting, or receiving health services directly from the Federal government.

Another key element of the strategy involves restructuring the agency. Last year, the Director formed the Indian Health Design Team (IHDT) which is composed of tribal leaders, urban Indian leaders, and IHS officials. The IHDT has proposed over 50 structural and operational changes to the IHS. These will significantly affect internal business operations of the agency. Mr. Lincoln also noted that all Indian health programs (including federally operated, tribal operated, and urban Indian health programs) need a strong business plan in coming years when federal funding will be "flat" at best.

Mr. Lincoln identified financial solvency for Fiscal Year 1996 as the most urgent immediate priority for the work group. One fourth of the fiscal year has passed and Congress has not yet finalized the IHS appropriation. He said that the work group must be

ggressive if we are to balance the books and maintain service continuity throughout the 1996. He noted that the affects of budget restrictions and unfunded costs are cumulative. The business plan must quantify and project revenue and cost factors into the out-years.

Mr. Lincoln said the business plan is only one part of the Director's overall strategy to create a new IHS for a new era. It is a critical starting point, however. Fiscal solvency is necessary to allow the other elements to succeed in adapting the IHS for a new era. He repeated Dr. Trujillo's observation that unless we undertake necessary changes, others will do it for us.

He closed by acknowledging the benefit of diverse views of work oup participants who come from ifferent backgrounds and who represent many stakeholders. He encouraged members to bring those views forward in the deeper spirit of partnership and with a will to work together on behalf of all Indian people.

Business Plan Ideas

The Business Plan Work Group members include elected tribal leaders, tribal health directors, business managers, accountants, physicians, nurses, federal executives, and private sector consultants. Members were asked to say what they wanted the IHS business plan to achieve. Some of their responses are.

- Identify new practices to enhance revenue.
  Plan how to provide better services, faster and at less cost.
- Develop capability to respond readily to changes in the market.
- Preserve quality as well as quantity of health care services.
- Harness business-like practices to improve the system.
- Build a unified corporate approach that benefits all (IHS, tribes, urban programs).
- Focus on multi-year time horizon (get out in front of change).
- Aggressively instill "managed care" practices.

4 Track Business Plan

The work group has identified four primary issues for its business plan. These are:

Revenue Generation - The business plan will project revenue trends from all sources, identify sources that have additional potential, and design measures to realize those gains.

Cost Control - the plan will quantify and project cost trends, identify factors driving unfunded increases, and pursue measures to control costs and maintain financial solvency.

Transfer Tribal Shares - the plan will quantify tribal shares (both under Title III compacts and Title I contracts) to be transferred, set a schedule for completion of transfers (at headquarters and at each individual Area Office), and identify measures to accomplish the transfer on schedule.

Internal Business Improvements - the plan will identify measures and a time-table for installing additional business-like practices to improve management and internal agency operations.

Cost Issues

The Business Plan Work Group requested detailed estimates of unfunded costs for FY 1996. These estimates were taken from the FY 1996 IHS budget request which uses inflation factors supplied by the Office of Management and Budget to project costs to maintain services at the FY 1995 level (current services level). A summary is presented in the table below. Estimates are approximate and subject to change.

'96 Unfunded Costs

Type	$ in millions
Payroll Increase	25
CHS Inflation	16
Contracts Inflation	31
Grants Inflation	5
Other (e.g. supplies)	9
New Retirement Contributions	6
TOTAL	92

Member Observations

The following observations were offered by members with respect to FY 1996 cost estimates.

- OMB supplied inflation factors may not reflect true medical inflation experienced by IHS and tribes.
- Members requested additional details on how the payroll cost increase was computed.
- Compare the relative costs of the civil service versus commission corps personnel employment systems.
- A better cost finding and accounting system is needed.
- The business plan must identify the break-even point for costs and identify benchmarks in order to

measure change.
- The cuts at BIA were a real wake-up call in Indian country.
- Drastic action to trim costs in the IHS is required. The business plan should identify these actions and potential savings.
- Put all budgets on the table for review including Sanitation and the Office of Environmental Health (these were, in fact, included in the cost estimates listed above).
- Federal law forbids offset of Medicare and Medicaid collections against IHS appropriations.
- If the IHS imposed "one federal price" on all Contract Health Service (CHS) purchases, overall CHS costs would, on balance, decline. Measures to prevent balance billing to patients would be required.
- HCFA has refused to withhold other medical payments to providers who decline to accept IHS patients at the "one federal price" rate. If one-federal price rates are implemented, the number of patient referrals to distant facilities could increase.
- Productivity of federal employees (e.g., # of patient services per employee) should be compared to private sector norms.
- Overhead costs at all levels are the highest priority for reduction.

Cost Control Priorities

The Business Plan Work Group endorsed the following as critical next steps to control costs.

- Apply a procurement regulations waiver to allow rapid rate quote. implementation where appropriate
- Freeze employee bonuses nation-wide in the IHS.
- Set budget limits for Service Units to control overtime expenditures.
- Freeze '96 IHS contracts/grants /compact at '95 levels (or '96 appropriation level if lower).
- Freeze CHS budgets at '95 levels (or '96 appropriation level if lower).
- Maintain hiring freeze and continue attrition to reduce the federal IHS workforce.
- Contract functions now performed by federal staff that are available commercially at less cost (this includes support functions at service units.)
- Test "prime vendor" sources for medical and other supplies in '96, implement fully in '97.
- Consolidate electronic transaction processing for personnel and certain finance actions.
- Freeze agency assessment" at '95 level. Plan to contract with alternative sources after 2 years.
- Further restrict travel expenditures by budget limits.

Freezing contracts and other procurement at '95 levels accounts for approximately one-half of the unfunded increases in FY 1996. The cumulative savings from other items is less clear. Area Offices will resubmit projections when the IHS' appropriation is passed. The Business Plan Work Group acknowledged that wholesale workforce reductions should be a last resort action to balance the budget.

Revenue Issues

Duane Jeanotte, Director of the Billings Area, summarized the IHS collections and the status of efforts to enhance collections.

Four Third Party Sources
- Medicaid
- Medicare
- Private Insurance
- Other

Medicare
- Started as a flat rate because of lack of cost data in the IHS.
- Rates established through HCFA, Dallas, Regional Office.
- Periodically increased for inflation over the years.
- Notwithstanding published rates, paid by DRG, bills are channeled through Data Center.

Medicaid
- Key source of revenue-Welfare Reform could be a problem.
- Areas establish an agreement with states using the Federal register published IHS rates.
- States often pay part B to increase Medicare revenue.

Private Insurance (PI)
- IHS fee schedules outdated-recently decentralized.
- Cultural shift to revenue motive not in place.
- Billing dependent on patient. registration, building design problems.
- Accounts Receivable module not fully implemented.
- Agreements with HMOs and risk based contracting.

Other Revenue
- Workmen's Compensation
- Auto insurance
- Other liability claims-Identification problems

Billings and Collections by IHS Area - FY'94

Medicare collected: $49,669,944
Medicare billed: $40,083,297

Medicaid collected: $104,531, 056
Medicaid Billed: $131,531,499

PI billed: $51,425,806
PI collected: 21,197,726

M&M Rate Increase

Harold Little summarized recent IHS efforts to raise the standard fee charged by IHS when billing Medicare and Medicaid. The IHS sent a letter to the Health Care Financing Agency (HCFA) requesting higher standard fees. The current flat all-inclusive rates are $95 per ambulatory visit and $495 per diem for inpatient hospital days. The letter explained that IHS standard fees (which are set by HCFA) are less than rates paid by HCFA to private sector providers. Mr. Little explained that HCFA uses the Diagnostic Related Groups (DRG) methodology to calculate rates of reimbursement for Indian patients billed to Medicare. This means that DRG based collections will not increase as a result of changes to IHS' flat rate. He indicated that new higher rates, if granted, could double Medicaid collections in some cases. HCFA has not yet responded. Mr. Little and other IHS staff will follow-up promptly.

Member Observations

The following observations were offered by work group members with respect to revenue enhancement.

- Certain prevention services could be billed under some circumstances.
- Consider paying patient's Medicare deductible to assure full eligibility for Part B collections. Could such payments be reimbursed as contract support costs for self-determination contractors?
- Consider contracting with commercial firms for all collections at a fixed percentage (i.e., 10%) of increased collections retained as compensation and incentive.
- IHS is billing for uncovered services in some cases and failing to bill for covered services in others.
- Should seek guidelines and legal approvals for entering "risk" contracts with HMOs and other firms that offer prospective payment for insured Indian patients. One interpretation of "Anti-deficiency" law suggests that this possibility is forbidden.
- Proposed national reforms to Medicare and Medicaid entitlements will limit collections by limiting the number of eligible people and reducing the time they are eligible.
- Detailed estimates of potential collections, billed amounts, and collected amounts compared for all service units should be sent to all Service Unit Directors. Hold them accountable for collecting less than the norm for comparable sites.
- Decentralized electronic billing is now possible in most IHS service units. Local control generates more incentive and capability for follow-up than through the centralized billing.
- Offer to fund state Medicaid eligibility examiners on-site at IHS and tribal health facilities. The cost is much less than the additional revenue generated by on-the-spot approvals.
- Establish and enforce a new policy that billing staff can not perform non-billing work until billing and collections work is completed.

Revenue Enhancement Priorities

The Business Plan Work Group endorsed the following as critical next steps to raise revenues.

- Raise M&M rates.
- Establish area specific private. insurance fee schedules by March
- Institute a new "charge master" during '96.
- Electronic billing capability at service units by March.
- Service Unit Collections Plan by January.
- Productivity Measures by January
- Visa/MC billing guidelines.
- Guidelines and policy to allow contracting with HMOs etc., on a prospective basis. Must resolve "risk," anti-deficiency issues, perhaps by reinsuring with stop-loss policies.

Medium Range Priorities:

- Buy and test an off-the-shelf state of the art billing system at a service unit.
- Develop a cost finding package capable of itemizing bills for privately insured patients.

Long Range Revenue Potential:

- Home health agencies revenue
- Nursing home revenues.
- Auto liability insurance, etc., revenues.
- Workmen's Compensation.
- Inventory of benefits/services (assign to Chief Medical Officers).

Tribal Shares Issues

The law authorizing transfer of federal resources to tribes under Title III self-governance compacts or Title I contracts was not intended to create new unfunded financial obligations for the IHS budget. Contracting or compacting for an IHS program transfers the resources from federal operations to tribes. The tribes take direct possession of resources already appropriated in the IHS budget and formerly controlled by the government.

The magnitude and pace of these financial transfers is a significant business concern. Additionally, there are one-time costs to convert non-cash assets to dollars. The law allows tribes to reconfigure programs and use

ansfered resources directly for program services. Reprogrammed resources create a new unfunded liability for contract support costs (CSC), typically 25% of the amount. Consequently, the business plan will identify tribal share transfers and related support costs separately from unfunded cost increases because of inflation.

Estimates of tribal shares due to Title I and Title III tribes during FY 1996 are presented below.

AREA OFFICE*	Estimated '96 Tribal Shares in millions of $
Title III Compacts	16
Title I Contracts	10
rea Total	26

HEAD-QUARTERS*	Estimated '96 Tribal Shares in millions of $
Title III Compacts	17
Title I Contracts	11
Headquarters Total	28

*Above estimates were obtained in October, 1995. Revised estimates to reflect recent data are being obtained.

Member Observations

The following observations were offered by work group members with respect to transfers of tribal hares to compacting and ntracting tribes.

- All "accounts receivables" and "receipts in the pipeline" should go to the compact when the tribe assumes a federal service unit (our best information is that this does occur).
- Whether 100% (or less) of tribal shares is made available upon request by compact/contracting tribes and on what time-schedule must be specified as an IHS policy.
- The IHDT proposed that the IHS track reassigned/redeployed resources in order to assure that tribal shares potentially transferrable to any tribe are not reduced.
- Definitions of residual should be the same among all IHS Area Offices.
- Future tribal applications for transfers of Area and Headquarters resources will be restricted unless action is taken to convert non-cash assets into liquid dollars for transfer.
- The policies governing Title I and Title III with respect to process, standards, and time frame for completing resource transfers should be the same.

Share Transfer Priorities

The Business Plan Work Group endorsed the following as critical next steps in transferring shares to tribes.

- Establish an IHS policy that Title I and Title III are the same with respect to eligible tribal shares and the schedule for completing transfer of shares to tribes. (OTA/OTSG/T3T)
- Conduct cash flow analysis of cash resources needed and available for transfer as tribal shares.
- Estimate '97 compacts and contracts requirements (T3T).
- Area Offices and Headquarters will identify tribal shares, actions to free up assets, and a schedule for completing transfers in their business plans.

The group identified some related issues for further work.

- IHS should debit transfers from specific accounts rather than from a general pool.
- What are the prospects for a Title I "shortfall" pool?
- Add the additional contract support costs that are generated as a result transfers to the projected costs table for inclusion in the business plan.
- A major stumbling block to transition is cash flow - the orderly gearing down and conversion of federal assets into cash takes time.

IHDT Restructuring

Cliff Wiggins, staff to the IHDT, summarized key recommendations from the IHDT final report. The recommendations generated a lot of discussion and several observations.

- Although members recognized that the final IHDT report establishes a framework for restructuring and is not a detailed implementation blue print, they said the plan does not adequately quantify costs and possible savings. Analysis of the "numbers" will be essential before proceeding with implementation.
- Transition costs will be significant (e.g., transfers, severance, etc.) and must be quantified as part of implementation planning.
- People may interpret IHDT proposed downsizing targets (25% for Headquarters and Area Offices), as available immediately when, in fact, transition costs will delay realization of savings into the out years. Members suggest that such delays and transition costs be prominently stated to Indian people to avoid losing credibility.

Business Practices

The time to identify and develop options for new business practices was limited. This topic will be undertaken in greater detail at subsequent meetings. Some initial ideas were offered.

- Budget simplification and expanded line-item flexibility.
- Allocate resources to the field within 30 days of receiving apportionment from the OMB.
- Assure continuous cash flow and even paced revenue collections throughout the fiscal year. Avoid financial obligations and liabilities that depend on extraordinary year-end collections.
- Reduce the number and detail of financial transactions in the central accounting system, especially for CHS which duplicates information maintained at the Fiscal Intermediary.
- Develop better cost accounting systems by 1) revising the existing system, and/or 2) purchasing add-on modules, and/or 3) test off-the-shelf accounting systems as alternatives at several service units.

Work Group Linkages

Work group activities that overlap with other work groups were identified and liaisons were appointed to assure that business plan work is coordinated and duplication is avoided.

IHDT - *Dick Mandsager/Maggie Terrance*

Doug Peter is to work with IHDT liaisons to update the IHDT at the January meeting. The Business Plan Work Group proposes to assist with IHDT implementation planning by strengthening its analysis of "the numbers."

Managed Care Committee - *Anna Albert*

This committee could take the lead on "rate quote", "1-IHS price", prime vendor, and other tasks to extend the buying power of CHS dollars. It should investigate grants with the Robert Wood Johnson foundation.

Baseline Measures - *Tony D'Angelo*

Identify key business performance indicators that could be applied uniformly to IHS, tribal, and urban Indian health programs.

Title III Transition (T3T) - *Don Davis*

A number of items listed in the section *Observations on Tribal Shares* above overlap with this group. Each Area Office and Headquarters must identify in tribal share transfers as part of its business plan.

Business Office - *Duane Jeanotte*

This sub- work group was created at the first business plan meeting to immediately develop and pursue measures to enhance revenues.

Director, Council of Area and Associate Directors - *Michel Lincoln*

National Indian Health Board - *Yvette Joseph-Fox*

Urban Indian Health Organizations - *Ralph Forquerra*

What should a business plan include?

Members of the work group proposed a multi-year matrix for projecting costs and revenues. The matrix will be developed into a computational model to analyze the impact of business plan actions (e.g., raising billing rates, reducing the work force, etc.) on financial shortfalls. Identifying the cumulative effects of such actions in the out years is a key feature of the business plan.

"Service demand" factors such as population growth, demographic changes, and health status could be added to the model.

Diagrams of proposed revenue and cost matrices are shown on page 8.

Membership

Mike Lincoln / Co-chair
IHS Headquarters
(301) 443-1083, Fax (301) 443-4794

James T. Martin / Co-chair
Executive Director,
United South & East Tribes
(615) 872-7900, Fax (615) 872-7417

Yvette Joseph-Fox
Executive Director,
National Indian Health Board
(303) 759-3075, Fax (303) 759-3674

Rae Snyder
School Child & Family Counselor
Prospect School
(716) 945-5170 Fax (716) 945-2374

Duane Jeanotte
Director,
Billings Area IHS
(406) 247-7107, Fax (406) 247-7230

ɔni Wilder
Executive Director, NW Portland Indian Health Board
(503) 228-4185, Fax (503) 228-8182

Luana Reyes/ Dick Church
Acting Director, Headquarters Operations, IHS
(301) 443-1083, Fax (301) 443-4794

Pearl Baller
President,
Quinault Tribe
(360) 276-8211, Fax (360) 276-4191

Doug Peter / Judy Kitzes
Acting Chief Medical Officer, IHS
Chief Medical Officer, Albuq. Area
(301) 443-1083, Fax (301) 443-4794

Charles Head
Cherokee Nation
(918) 456-0671, Fax (918) 456-6485

dia Hubbard-Pourier
Executive Director, Riverside San Bernardino Indian Health Inc.
(909) 849-4761, Fax (909) 849-5612

Jack Markowitz
Office of Administration & Management, IHS
(301) 443-7493, Fax (301) 443-9646

Dick Mandsager
Director,
Alaska Native Medical Center
(907) 257-1823, Fax (907) 257-1781

Ralph Forquera
Director,
Seattle Indian Health Board
(206) 324-9360, Fax (206) 324-8910

Anna Albert
Director, PIMC &
Chair, Managed Care Committee
)2) 263-1567, Fax (602) 263-1699

Larry Nuckolls
Governor,
Absenttee Shawnee Tribe
(405) 275-4030, Fax (405) 275-5637

Dorothy Dupree
Executive Officer,
Albuquerque Area, IHS
(505) 248-5429, Fax (505) 766-2175

Cindy Hanson-Sacks
Executive Officer,
Alaska Area, IHS
(907) 257-1155, Fax (907) 257-1168

Carol Mitzel
Medical Records Officer,
Billings Area, IHS
(406) 247-7128, Fax (406) 247-7132

Support Staff

Cliff Wiggins
Operations Research, IHS Headquarters
(301) 443-7261, Fax (301) 443-4794

John Breuninger
Special Assistant,
IHS Headquarters
(505) 837-4111, Fax (505) 837-4115

Keith Longie
Associate Area Director for Planning,
Phoenix Area, IHS

Anthony D'Angelo
Division Director, Statistics, IHS
(301) 443-1180, Fax (301) 443-1522

Nancy Davis
Division Director, Contract Health Care Office, IHS
(301) 443-2694, (301) 594-6213

Michelle Duran
IHS Headquarters
(505) 837-4101, (505) 837-4115

Outside Consultants

Ward Hurlburt
Talbert Medical Management Corporation
(801) 355-1236, Fax (801) 531-9003

Mario Gonzalez
First Nations Community Health Source
(505) 262-2481, Fax (505) 262-0781

Joe Hafey
California Public Health Foundation
(510) 644-3700, Fax (510) 644-9319

Sherry Salway-Black
First Nations Development Institute
(703) 371-5615, Fax (703) 371-3505

Terry Batliner
Veterans Administration
recently with Harvard Medical Plan

Martin Hickey
Lovelace Health Systems
(505) 262-3135, Fax (505) 262-7729